SEMINOLE TRIBE OF FLORIDA CENTER FOR BEHAVIORAL HEALTH ELECTRONIC REFERRAL FORM

Hollywood ☐	**Big Cypress** ☐	**Brighton** ☐	**Tampa** ☐	**Immokalee** ☐
111 West Coral Way Hollywood, FL 33021 Phone: 954-964-6338 Fax: 954-967-5182	31000 Josie Billie Hwy Clewiston, FL 33440 Phone: 863-902-3206 Fax: 863-902-3205	500 Harney Pond Road Okeechobee, FL 34974 Phone: 863-763-7700 Fax: 863-763-6338	6401 Harney Rd Ste E Tampa. FL 33610 Phone: 813-620-2865 Fax: 813-612-5639	1130 South 1st. St Immokalee, FL 34142 Phone: 239-867-3480 Fax: 239-657-2382

Date of Referral _____ **Referring Reservation** _____

Name of person referring/Contact Information _____

Referring Department _____

Client Information

Client Name		Male ☐ Female ☐		Date of Birth	
Tribal ID				Clan	
Address		City		Zip Code	
Home Phone		Cell Phone			
Email address					
Language spoken in home		Reservation			
School (if applicable)				Grade	

If client is a minor or under any guardianship, please complete parent/guardian information section below

Parent/Guardian Information

Parent/Guardian Name		Male ☐ Female ☐		Date of Birth	
Tribal ID				Clan	
Address		City		Zip Code	
Home Phone		Cell Phone			
Email address					
Language spoken in home		Reservation			
Relationship to Client/Type of Guardianship					

1. **Referral need or presenting problem** (e.g. substance abuse, mental health, behavioral concern, etc.)

2. **How long has this issue/behavior been a concern?** _____

3. **Previous interventions that have been tried. What worked and did not work?** (e.g. treatment program, medications, counseling, etc.).

_____

_____

4. **Please list special types of therapies/interventions used in the past**

_____

5. **Please explain if there are any medical conditions or concerns present**

_____

6. **Please explain the client's social/ emotional status** (e.g. isolating, depressed, etc.)

_____

7. **Additional concerns or general information.**

_____

8. **Type of service being requested/recommended.**

☐ **Developmental Screening** ☐ **Speech-Language Pathology** ☐ **Occupational Therapy**
☐ **Physical Therapy** ☐ **Behavior Analysis** ☐ **Mental Health Assessment/Counseling**
☐ **Substance Abuse Assessment/Counseling** ☐ **Aftercare Recovery Services**
☐ **Psychiatric evaluation/services** ☐ **Bariatric evaluation/counseling services**
☐ **Psycho-educational evaluation** (measures intelligence and academic functioning)
☐ **Psychological evaluation** (measures social and emotional functioning)
☐ **Guardianship evaluation**
☐ **Other** _____

9. **Client and/or parent/guardian's response to referral.** (e.g. open/positive, resistant, ambivalent, etc.)

_____

Office use only:

Assigned to _____ **Date** _____

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Referral Response/Action Taken

TO: _____ FROM: _____

Sent Via: ☐ Fax ☐ Mail ☐ In-person ☐ Other _____

Comments: _____

Signature: _____ Date: _____